Incapacitated Child Certification Form

This information is required to substantiate incapacity for an eligible dependent child (must be established prior to age 19 or while an eligible covered full-time dependent student—within 31 days of loss of full-time student status). Student certification from the college must also be attached so that eligibility at the time of incapacitation can be verified.

SECTION A (To be completed by the subscriber)

Subscriber's Name:	**Subscriber's Social Security Number:**
❑ **Active Employee (list Group Name & Number):**	❑ **Retiree** ❑ **COBRA** ❑ **Survivor**
Dependent's Name:	**Dependent's Date of Birth:** **Dependent's Social Security Number:**

Is this dependent covered by any other health benefits, including Medicare/Medicaid?
__ No __ Yes
If yes, list the name of the other insurance carrier:_____
Effective date of other coverage:_____
Policy Number of other coverage:_____
Has dependent applied for Social Security Income? ____No ____Yes
When did this incapacitation begin?_____

Is the dependent married? ____ No ____Yes
Has the dependent ever been married? ____No ____Yes

Is the dependent living at home? ___ No ____ Yes
If no, where does the dependent reside?_____

Is the dependent employed? ___ No ___ Yes (If yes, please indicate where and the approximate number of hours worked weekly?_____
_____

Has the dependent ever been employed? ____No ____Yes
If yes, time period of last employment:_____

I hereby certify that all information provided is correct to the best of my knowledge and that this dependent is incapable of full-time student status and self-support and remains dependent upon me for support and maintenance. I hereby authorize Employee Insurance Program personnel to contact the health providers, to request claims history, and to confirm student status history as needed to obtain necessary information concerning my dependent's incapacity and eligibility. I understand that it is my responsibility to notify the Employee Insurance Program within 31 days of any change in eligibility of this dependent and that EIP may review the status to verify continued eligibility. Failure to notify EIP of changes in eligibility status may result in penalties and recoupment of benefits paid on behalf of the ineligible dependent.

_____ _____

Subscriber's Signature **Date**

SECTION B (To be completed by the dependent's physician)

Date incapacity began:	**Date this individual was last examined by you:**

Diagnosis and description of the incapacitation:_____

Current treatment frequency and description:_____

Additional services or coordination of care:_____

Is the dependent institutionalized? ___No ___Yes If yes, give the name of the institution:_____
Dates of confinement:_____
Nature of care:_____

If the diagnosis is psychiatric, please complete the following section:
Complete DSMTV diagnosis required with descriptors, codes and severity specifiers:
Axis I:_____
Axis II:_____
Axis III:_____
Axis IV:_____
Axis V: current:_____**highest in the last year**:_____

Is the dependent fully compliant with treatment? ____No ____Yes
If no, might the prognosis be different if he/she were compliant?_____

Has the dependent been hospitalized for a psychiatric condition? ____No ____Yes
Date and facility:_____

What is the nature and degree of the dependent's impairment in relation to his/her capacities for:
Daily activities:_____
Task performances:_____
Social interaction:_____

SECTION B continued

In your professional opinion would you consider this individual to be <u>permanently and totally</u> incapacitated and incapable of self-support and incapable of full-time student status (i.e. the individual will always be dependent upon someone else for support and maintenance and never capable of full-time student status or self-support)? ___No ___Yes (If the diagnosis is mental retardation, please provide the mental age or I Q: _____
Would you consider the individual to be temporarily incapable of full-time student status and temporarily incapable of self-support? ____No ____Yes **If yes, what is the anticipated date this individual will be able to seek employment or return as a full-time student?_____**

I hereby certify that all information provided in SECTION B above is correct to the best of my knowledge.

Physician's Signature	**Date**	**EIN/SSN**

Print Physician's Name	**Physician's Telephone Number**